

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 27, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799, Chronic Pain Management, per hour 10 Sessions/80 Hours (5 days a week for 2 weeks)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified PM/Occupational Medicine with over 34 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a female who while working as a reports an injury on xx/xx/xx in that she was involved in a breaking up a fight between two students at school and was kicked in the leg and injured herself pulling them apart in a twisting-type mechanism. She has pain in the base of her neck, pain radiates across the lower back towards her groin on the right side, pain towards her right shoulder and her left knee.

12-24-98: Medical Records Prior to Date of Injury. In these records the claimant was seen by on 8/9/04, 8/30/04 for complaint of severe lumbar back pain described as spasms with radiation down both legs. She was prescribed Vioxx, Hydrocodone/APAP 7.5/500, and Flexeril for management which did improve symptoms. MRI of lumbar spine w/o contrast on 8/21/04 showed: 1. Mild degenerative change. 2. L4-L5 – Small central disc herniation along with bilateral facet arthropathy causing mild central canal and bilateral neural foraminal stenosis. On 10/8/04, Dr. added Celebrex to claimant's medications for continued complaints of lower back pain. On 11/12/04, X-ray of cervical spine, 5 views dictated by MD indicated multilevel cervical spondylosis and no fractures or subluxation. 11/24/04 follow up note dictated by MD, claimant stated she was having a popping discomfort that radiates across the left trapezius area and goes away. On physical examination Dr. noted good ROM of cervical spine, no radicular radiation in the upper extremities. 4/9/05, claimant underwent medial meniscus repair and partial patellectomy with repair on the left by, MD. X-ray of lumbar spine, 3 views on 1/22/10 dictated by xxxxx, MD with Impression: 1. Degenerative spurring. 2. Constipation. Also on 1/22/10, X-ray of sacrum, coccyx AP-LAT views dictated by, MD showed normal appearance, and that a CT scan or bone scan can be performed for further evaluation.

09-30-10: Encounter Notes dictated by, MD. Claimant presented with back, neck, shoulder and knee pain. Physical Examination: Axial skeleton: Mild right sided spasm of the trapezius. Normal range of motion without pain. Minimal para spinal spasm noted. Lower Extremities: Left knee is slightly swollen, tender patella, stable joint. Assessment: Near fall with multiple injuries, left knee sprain, right shoulder strain, cervical strain, and low back strain. Plan: NSAIDs, muscle relaxer, and pain reliever; activity as tolerated, no heavy lifting; claimant is a teacher and should be able to perform her job as it is not physically demanding; refer to orthopedics to treat injuries especially to the left knee. Medication: Naprosyn, Skelaxin & Darvocet.

10-05-10: Office visit dictated by MD. Claimant has a significant past medical history, review of systems is positive for depression, forgetfulness, loss of sleep, loss of weight, nervousness. She is allergic to codeine. Claimant stated that she had some preexistent balancing problem. She presented with back, neck, shoulder and knee pain. Physical exam: Claimant is tender following the base of the neck. Mild symptoms produced across the shoulder. C-spine series with flexion and extension shows stable c-spine, but preexisting deteriorating disc space height at C3-C4, C4-C5, and C5-C6. There is a spur formation, some

chronicity to the problem, although she states she was asymptomatic prior to this injury. Claimant has some impingement symptoms and elevation in forward flex and abduct position in the 60-degree through 90-degree range of lumbar spine, and should respond to physical therapy. Neck has some discomfort at all extremes and extension, flexion, lateral bend. LS spine series does show anterior spur formation in anterior bodies of L4 and L3. Disc space height are fairly well maintained except at L5-S1. X-rays: AP, lateral x-ray of the right shoulder and oblique show type 2 acromion, mild AC joint deterioration, all age persistent. Plan: All issues on exam should respond without surgical intervention. Restrictions for work are: walking less than 100 yards at a time, avoid squatting, kneeling and avoid overhead work.

10-08-10: Visit note dictated by MD. "Patient should not take medication during work hours if she feels it makes her unsafe. Patient seems to be very interested in missing work. She should stop the medications if she can't work on them. Patient is to see orthopedist for care as soon as possible. Her pain and "suffering" is much greater than expected with this motor injury".

10-25-10: Physical Therapy Initial Evaluation dictated by PT. Chief complaint: pain in the right shoulder, left knee and right side of the neck and lumbar back pain rated currently at 8/10 and at worst 10/10. Pain is aggravated with moving around too much and relieved sometimes by medication and resting. Plan: Short term goals: in two weeks claimant will: 1. Increase ROM R shoulder flex to 110, abd 110, ext to 45, L knee flex to 120. 2. Decrease pain level by 10%. 3. Demonstrate independence with HEP. 4. Increase strength L hams to 5/5. Long term goals: in one month claimant will: 1. Increase ROM trunk to FB 75% and R shoulder flex to 120, abd 120. 2. Decrease pain level by 20%. 3. Demonstrate ability to pick up item from floor correctly and without pain. 4. N/A. 5. Educate in body mechanics and posture. 6. Return to work. Frequency: 3x/week for 4 weeks as medically indicated to attain goals. 9 visits per approval.

11-02-10: Office visit dictated by MD. Claimant has had a slow response as she has been delayed in getting her physical therapy approved. She is just now getting approval to start her left knee. Left knee, she is wearing a sleeve. She has chronic symptomatology across her knee. Objective: Flexion causes discomfort essentially across the patellofemoral joint and external rotation reveals a signs without clicking, without an effusion. Bilateral neck pain that radiates from the occiput towards the superior medial corner of the scapula. Plan: Claimant needs to finish her physical therapy and will assess at this point. Switching medications as claimant is not getting relief from Skelaxin to Flexeril, Naprosyn and Darvocet.

11-29-10: Office visit dictated by MD. MRI ordered of left knee and will later six weeks down the road her low back.

12-16-10: MR Knee JNT WO Contrast dictated by MD. Indication: Left knee pain. Impression: 1. Postoperative changes at the patella with susceptibility

artifact within the bone. The patella itself appears shorter than expected and a part may have been removed. No acute osseous abnormality is identified. There is some thickening of the ligaments of the extensor mechanism but ligaments are intact. There is no demonstrable chondromalacia in the patella. 2. Small joint effusion. 3. Tendons and ligaments and menisci are intact.

12-21-10: Office visit dictated by MD. MRI does not show any new injury that can be directly true except for her pre-existing problems. Low back pain persists, but when she is in a sitting position I can get up through 90 degrees without getting radicular increasing symptomatology. On examination, she is tender across her inner spinous areas from SI joint, SI joint then up to the right area in the paravertebral flank, but no palpable spasms noted today on examination. Plan: Claimant informed that she will most likely not qualify for scan without localizing neurologic deficit or sciatic type pain, but she wishes to dispute and proceed that route. At this point there is no restriction to her knee and her back is going to be related by pain; follow up in four weeks. Need MMI rating.

01-18-11: Office visit dictated by MD. Claimant presented with pain and hypersensitivity across her old scar on left knee from a direct contact with no effusion and no heat temperature or discoloration. No instability on examination. She complains of low back pain that centers near the SI joints and goes proximal on her right side. Tight lateral bend increases and left lateral bend produces little on the left side. They are not going to approve an MRI with nonradicular pain, but with persistent symptomatology I think she should have a bone scan to rule out fracture that occurred anywhere near the SI joint. Right shoulder: forward flexion, claimant starts acting like a ratchet-type pain which appears to be some subjectively driven at about 40 to 45 degrees and will not lift above 90 degrees. Abduction starts about 65 degrees and she complains of abduction being more severe. She will internally rotate three or four thoracic levels lower than on her left shoulder and this is a positive right shoulder impingement. She has had plenty of time recovered. She should have MRI of her right shoulder at this time. She complains of extension pain and when she bends her neck back lateral bends to 30 degrees and twisting about 35 to 40 degrees, she complains of pain at all extremes with some centrally complaints going distally, but no localizing motor deficits on the upper extremity exam.

02-22-11: Office visit dictated by MD. Claimant continues to have right knee pain persistent with anterior patellofemoral problems with direct load and crepitation in minimal or negligible. No effusion. Objective: MCL, LCL, ACL, PCL are intact. Presume static arthritis point. Right knee with persistent symptomatology. She still has some symptoms where she feels are down in her ankle and she relates it to her back, but her sciatic tension signs are negative. No motor deficits distally. Right shoulder pain and she does not lift above 100 and 105 degrees max, resistance is only grade IV, internal rotation is only to lower thoracic area where the contralateral shoulders to mid thoracic to high thoracic. This will all be consistent with impingement or small tear in shoulder, for which MRI has been denied. Plan: Released with permanent restrictions. MMI scheduled in March.

03-19-11: Designated Doctor Evaluation dictated by, MD.

Determinations/Conclusions: MMI: Claimant is at Maximum Medical Improvement for lower back, neck, right shoulder and left knee strains as of 12/29/10. Small focal right rotator cuff tear condition, possibly degenerative in nature, is at Maximum Medical improvement if no other treatment option is considered. Impairment Rating: DRE Cervicothoracic Category I of 0%; DRE Lumbosacral Category II or 5%; Left knee 0% (It is noted that the measured bilateral range of motion is decreased equally); Right shoulder range of motion, 7%; All combined: 12% whole person impairment rating.

03-24-11: MR Lumbar Spine WO Contrast dictated by MD. Indication: pain. Impression: 1. multilevel degenerative disc disease. 2. At the L4-L5 and L5-S1 levels, there is some narrowing of the lateral recesses bilateral at the L4-L5 level and on the left at the L5-S1 level. There may be some encroachment on the traversing nerve roots at these levels. There is no significant spinal stenosis or neural foraminal narrowing at these or any other level in the lumbar spine.

03-24-11: MR Shoulder JNT WO Contrast dictated by MD. Indication: Shoulder pain. Impression: 1. near full-thickness articular-sided focal tear of the supraspinatus with associated moderate tendinopathy. 2. Possible minimal tendinosis of the biceps tendon. 3. Chondromalacia at the glenohumeral joint.

04-05-11: Office note dictated by MD. Dr noted that at this time, forward flexion pain starts approximately 80 to 85 degrees and maximum effort is approximately 110 degrees with discomfort. Abduction starts at about 80 to 85 degrees, maximum effort approximately 115 to 120. Resisted-infraspinatus appears to be grade 5 or 5-. Resisted supraspinatus is grade 4 and painful. Resisted subscapular appears to be grade 5. Maximum internal rotation is limited. MRI shows partial tear, articular side; this condition is consistent with findings. Claimant needs surgical repair for partial near full-thickness tear rotator cuff. Claimant has had therapy and failed, and does not want to live with her symptoms. Claimant has persistent symptomatology as far as her spine goes. She uses chronic allergies in between, probably using analgesics in the form of hydrocodone and she is on Tramadol right now because of her persistent symptomatology that has not been relieved and statistically history is that persist this long is likely to be of a permanent nature.

04-26-11: Office visit dictated by MD. Claimant stated that she will have her shoulder surgery this summer. Objective: Left knee is in a sleeve at this time. Claimant is using a cane, and is slow to stand from sitting position. She tends to keep her back sloping forward about 5 degrees. She can bring herself to neutral, actually gone extension about 10 degrees with discomfort. Right shoulder, forward flexion pain initiates at about 65 degrees. She will bring it up to about 105 degrees. Adduction pain does not start until she gets near 90 degrees. Plan: Work release with restrictions considered reasonable and extended till the end of the school year.

06-20-11: Office visit dictated by, MD. Dr. noted on examination, persistent symptomatology, today her neck is one of her worse symptoms radiating from the posterior aspect towards the right side shoulder and the short extensors of the neck. Extension past about 20 degrees rapidly produces increasing symptoms and she does not prefer to do that. She can rotate to about 45 degrees, laterally bends approximately 25 degrees. Persistent shoulder pain symptomatology with impingement-type complaint associated with abduction and forward flexion and a normal 75 to 90 degrees abduction position and will have breakaway discomfort associated with that. This issue has not been addressed. Referral to pain clinic for management of her neck and she has persistent lumbar symptomatology that is nonsurgical issues at this point.

07-26-11: Orthopedic Specialists Initial Evaluation dictated by, MD. Claimant's pain is localized to the AC-anterior subacromial area. She has pain overhead out to the side, painful arc range, and trouble with activities of daily living. Claimant is right-hand dominant. Medications: hydrocodone and cyclobenzaprine. Physical examination: Claimant has weakness of the supraspinatus, 4/5. Painful arc range between 90 and 130 degree range. Tenderness over the supraspinatus insertion site, anterolateral acromion, and AC joint. Impression and Plan: Apparently, the insurance company is only covering the shoulder strain, although it is a broad term to describe an acute injury which is a strain that is more of a provisional diagnosis. The definitive diagnosis was then made by MRI, physical exam and history. Clearly, she has a partial-thickness rotator cuff tear and, clinically, acromioclavicular joint inflammation. Based upon that, her definitive diagnosis is partial-thickness cuff tear and acromioclavicular joint inflammation. None of these are degenerative in nature and it fits with her mechanism of injury with a violent altercation that she was trying to break up. She has had inflammatory medication, physical therapy, and no injections. Recommending a right shoulder subacromial acromioclavicular joint injection of lidocaine, Marcaine, and a total of 80 mg of Depo-Medrol under ultrasonic needle guidance.

08-03-11: RX Guardian Results Report dictated by MD. The presence of Marijuana metabolite has been confirmed. This is evidence of Marijuana use or taking a medication such as Marinol, which contains delta-9-THC (marijuana's active ingredient).

12-03-11: Designated Doctor Evaluation dictated by, DO. Extent of Injury Determination: Mechanism of injury and Physical Exam Findings are consistent with Right Shoulder Rotator Cuff Injury. The claimant consistently reported Right Shoulder pain throughout the medical records, however did not receive an MRI until approximately 6 months after her injury. The Right Rotator Cuff Injury is part of the extent of Injury.

01-11-12: Orthopedic Specialist Follow up dictated by, MD. The claimant states her shoulder has worsened. She has lost range of motion and is in quite a bit of

pain particularly at night when trying to sleep. Claimant has tried Tramadol and hydrocodone, both of which prevent her from sleeping and do not help with her pain. On physical exam, tenderness to palpation over the lateral and subacromial area. Painful arc range between 90 and 120 degrees of abduction, forward flexion to 140 degrees, external rotation to 40 degrees, and internal rotation to L3. Cuff strength is 5/5 on internal and external, and 4+/5 on supraspinatus testing. Markedly positive Hawkins impingement sign. Impression and Plan: Right shoulder partial-thickness rotator cuff tear and impingement with acromioclavicular joint inflammation. ESI received. Ice application discussed in the event of increased pain. Follow up in 6 weeks. Flexeril given to help with muscular pain as well as Voltaren 75 mg PO BID to reduce inflammation. Work restrictions: no lifting, pushing, or pulling over 15 pounds.

02-22-12: Electrodiagnosis of the Lower Extremities dictated by DC, FABES, RNCST, CNCT. Electrodiagnostic Impression: There is no evidence of left or right lumbar radiculopathies, sacral plexopathies, focal peroneal or tibial neuropathies in their knee or ankle segments, medial or lateral plantar neuropathies in their ankle or foot segments, lower limbs peripheral polyneuropathies, or myopathies.

03-12-12: Initial Interview at dictated by MA, LPC. Objective Findings: Claimant's psychological symptoms appear to be marked by the following: appetite increase, sadness, hopelessness, insomnia, energy decrease, frustration, irritability, crying spells, motivation decrease, boredom, decrease libido, discouragement about the future, feelings of inadequacy, inability to relax, muscle tension, difficulties adjusting to injury, panic, restlessness, rapid heartbeat, nervousness, fear of re-injury, concentration difficulties, increased concerns about physical health. Currently claimant is taking Pristiq, Clonazepam, and Cyclobenzaprine. Current Complaints: Claimant reported pain in her neck, and middle and lower back, which seems to radiate down her back of her leg as well; described as constant, burning, dull, throbbing, and aching. The claimant reported sleeping about five hours at night; however, very interrupted due to pain and racing thoughts that she experiences. The claimant reports that she is very weak and cannot perform basic activities in her life. She reports that her levels of strength, mobility and endurance are lower than they have ever been. The claimant reported that she has always been very active throughout her life; however, she now finds herself avoiding any forms of activity that are not necessary for treatment due to her fear of re-injury. BDI-II: 39; BAI: 38; SOAPP-R: 17; FABQ: work scale = 27 out of 42, activity scale = 24 out of 24. Impressions: There is a strong indication that the claimant is experiencing pain that is creating interference in her life. It appears as though she is having long-term adjustment problems of depression and anxiety which are secondary to her work-related injury. Recommendations: It is recommended that the claimant be seen for 6 sessions of individual psychotherapy to address high levels of stress and depressive symptoms to help patient increase management of her chronic pain. She has a high potential to benefit from therapy and psychological interventions given her employment history and her motivated drive to remain as productive as

possible. Treatment Goals: 1. Decrease emotional distress, depression, anxiety as related to impact and pain from her job-related injury. 2. Assist her in developing alternative methods to manage her fears and pain more effectively. 3. Help the patient increase adjustment to lifestyle changes secondary to impact of work-related injury. 4. Aid patient in dealing with specific stress-related issues that may hinder rehabilitation, including maladaptive beliefs regarding condition, fear of re-injury. 5. Identify the negative, distorted cognitions that mediate intense negative emotions and assist the patient to increase verbalization of realistic, positive self-talk. 6. Learn relaxation techniques that will afford the patient help with stress and pain.

03-12-12: New Patient Encounter dictated by MD. Chief complaint(s): lower back pain radiating down bilateral legs; shoulder pain-right. Pain is aching, burning, and sharp, shooting, stabbing, throbbing, weakness right shoulder. Triggers: while working, when standing, while walking, with any activity. Modifying factors: Worsens: "suddenly", while walking, with activity, with exercise, while sitting, with standing. Associated s/s: leg cramps, stiffness, weakness. Exam: Right shoulder joint tenderness noted internal rotation could not be performed. Claimant walks with a cane. Tenderness noted to lumbar spine. Problems: Chronic Pain Syndrome, lumbago, lumbar/thoracic radiculopathy, lumbar disc degeneration, lumbar disc herniated, pain shoulder. New Medications: diclofenac sodium 75mg PO daily; Flexeril 10 mg PO q8hrs; Lyrica 100 mg PO TID; Norco 10-325mg PO q6hrs PRN pain. Claimant continues to work, tries to tolerate job duties well but difficult. Current medication providing adequate relief of pain symptoms, denies side effects. May continue to work with restrictions. Disposition: Request approval for L4-L5, L5-S1 TF ESI; also get approval for right shoulder ESI; appointments scheduled upon approval.

04-02-12: Office visit dictated by MD. Claimant presented with pain tingling stiffness weakness in the right neck, shoulder, arm, mid back, low back, hip, knee, lower leg and foot. The claimant reports ongoing pain of 2 years with frequent pain that awakens her from sound sleep and limits her ability to use the right upper extremity. Previous injection of the right shoulder provided the claimant with no improvement even during the anesthetic phase. Current medication: Flexeril. Right shoulder examination: Tenderness to palpation at the a. c. joint as well as over the rotator cuff insertion. There is some weakness on external rotation strength testing secondary to pain. Provocative testing not possible secondary to significant pain involving the right shoulder. Positive impingement test. Assessment/Plan: Impression: 719.41 Shoulder pain. Because of the inadequate response to anesthetic phase injection of the right shoulder subacromial space, it is unclear the degree to which the pain is related to the abnormalities identified on the previous MRI. Possible C-spine origin should be considered. If shoulder origin pain could be confirmed with repeat injection, diagnosis would include traumatic exacerbation of underlying rotator cuff tendinosis. Comorbidities Noted: depression, elevated cholesterol, fibromyalgia, hypertension, osteomyelitis and seizures. Treatment Plan: Recommend repeat subacromial injection to confirm shoulder origin pain relief during anesthetic

phase. Ultimately, subacromial decompression and distal clavicle resection with possible rotator cuff repair depending on size and grade of partial rotator cuff tear may be required.

04-19-12: Established Patient Encounter dictated by MD. Claimant complains of lower back, right shoulder pain with a pain level of 10/10. Problems: acromioclavicular (joint) (ligament) sprain; thoracic or lumbosacral neuritis or radiculitis unspecified, sprain lumbar region. Plan Note: This claimant is having radicular-type pain unresponsive to conventional noninvasive treatments such as physical therapy, rehabilitation and the use of medication for more than four weeks. Recommend ESI to reduce the level of pain. Disposition: Claimant has completed 6 sessions of physical therapy which did not help her very much. Medications refilled. Recommend transforaminal ESI injections to help alleviate her pain and to decrease her inflammation.

05-22-12: New Patient Surgical Consultation dictated by, MD. Claimant presented with back pain and bilateral leg pain, worse on the right associated with shoulder pain referred from the neck. Physical examination: Physical examination of her back and lower extremities reveals positive spring test, interiliac crest line, positive sciatic notch tenderness bilaterally, although worse on the right, positive extensor lag, positive flip test bilaterally, positive Lasegue's on the right at 45 degrees, positive Bragard's on the right, equal and symmetrical knee jerks, absent posterior tibial tendon jerks bilaterally, hypoactive ankle jerk on the right, paresthesias in the L5 and S1 nerve root distribution on the right and weakness of gastroc-soleus on the right. Assessment: Lumbar HNP L4-L5 and L5-S1 with clinical instability L5-S1 with failure of conservative treatment nearly two years. Plan: At this point in time, the claimant basically has two options, to accept her current disability and get on with her life to proceed with surgical intervention. I would like to have provocation discography to delineate clinical symptomatology at L4-L5 and L5-S1 with a control, but at this is not allowed by ODG, it will support less to ask for this. If claimant demonstrates no clinical instability in L4-L5, we could get by with a laminectomy with decompressive discectomy and decompression of her stenosis L5-S1. Will need a instrumented arthrodesis with reduction of her subluxation and functional spinal unit collapse to restore her sagittal balance. Claimant understands that this is an elective case; choice to proceed is based upon her workup, her failure of conservative treatment and her continued clinical symptomatology.

05-23-12: MRI Scan Review dictated by MD. Dr. xxxxx noted that on review of the MRI scan of the lumbar spine films reveals L4-L5 and L5-S1 noncontained disc herniation rated at stage II with annular herniation, nuclear protrusion, and disc desiccation consistent with T2-weighted image changes and spinal stenosis. Would recommend provocation discography to delineate clinical symptomatology as indicated.

06-07-12: Individual Progress Note 1 of 6 dictated by, MA, LPC. Claimant answered the telephonic session with a depressed mood as elevated by her tone.

The claimant sounded lethargic at times. When approached with this observation, she reported that she experiences high levels of stress due in part to her chronic pain. The claimant disclosed openly to the therapist regarding her living environment and current stressors related to her injury. Therapist used empathetic listening to help client develop insight into her chronic pain. Therapist will provide psychoeducational material to help claimant to better understand the process of chronic pain. She does not participate in activities which help to manage her stress.

06-13-12: Individual Progress Note 4 of 6 dictated by, MA, LPC. The claimant attended the session with a depressed mood as evidenced by her tone and flat affect. The claimant sounded lethargic at times. She processed her feelings towards her possible retirement with the therapist and expressed feeling of ambivalence towards no longer working. Therapist reviewed ways in which she can continue to feel like a contributing member of society despite being retired.

06-14-12: Individual Progress Note 5 of 6 dictated by MA, LPC. The claimant attended the session with a depressed mood as evidenced by her tone and flat affect. The claimant sounded lethargic at times. Claimant discussed her upcoming retirement and discussed ways to maintain her self-esteem. Therapist revealed ways in which she can continue to feel like a contributing member of society despite being retired. Claimant left the session with an improved mood as evidenced by her tone.

06-15-12: Individual Progress Note 6 of 6 dictated by, MA, LPC. The claimant attended the session with a depressed mood as evidenced by her tone and flat affect. The claimant sounded lethargic at times. Claimant reviewed the coping mechanisms, she had discussed with the therapist in the previous sessions. She explored her retirement further and reviewed ways to maintain a healthy sense of self esteem throughout it. Claimant left the session with an improved mood as evidenced by her tone.

07-06-12: Office visit dictated by, DC. The claimant presented with worsening LBP with radiation and unchanged UE complaints. Recommend FCE/physical for trial CPM. Continue current HEP.

07-18-12: Request for Services 10 Sessions of Chronic Pain Management Program dictated by, MA, LPC. Recommending the claimant to participate in our Multidisciplinary Chronic Pain Management program to aid the claimant in dealing with depression, anxiety, ad pain symptoms associated with both psychological factors and a general medical condition and chronic pain. The claimant has not been able to return to work due to high levels of stress daily and lacking overall physical functioning. She reported so much pain that she has a difficult time structuring her life, remaining positive, and being motivated to perform necessary actions for a successful recovery. BDI-II: 39; BAI: 38. This claimant meets the criteria for the general use of multidisciplinary pain management program; according to ODG, chronic pain chapter. Summary: The pain resulting from her

injury has severely impacted normal functioning physically and interpersonally. The claimant reports frustration and anger related to the pain and pain behavior, in addition to decrease ability to manage pain. Claimant has reported high stress resulting in all major life areas. The claimant will benefit from a course of pain management. It will improve her ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting her daily functioning. Claimant should be treated daily in a pain management program with both behavioral and physical modalities as well as medication monitoring. The program is staffed with multidisciplinary professionals trained in treating chronic pain. The program consist of, but is not limited to daily pain and stress management group, relaxation groups, individual therapy, nutrition education, medication management and vocational counseling as well as physical activity groups. These intensive services will address the current problems of coping, adjusting, and returning to a higher level of functioning as possible.

07-18-12: Comprehensive Functional Capacity Evaluation dictated by DC. Claimant is not capable of physically performing all of her pre-injury work demands, and maximum PDL are in the Light PDL. Her present functional abilities are in the Less Than Sedentary PDL. She is unable to tolerate prolong standing and sitting that is required to perform her regular job duties and is unable to tolerate critical job activities without increased low back pain at this time. The claimant is currently meeting all of her pre-injury demands. Functionally she is not meeting all of her job requirements due to her complaints of moderate to severe pain sensations of 7/10 to 8/10 during testing and exhibited some outward pain behavior patterns and acute distress. Her subjective complaints are consistent with clinical observations of function and mobility. Recommendations: Recommend that the claimant transition to an aggressive and structured rehab regimen to address her physical and functional deficits and return her to the active work force. Recommend 10 sessions of Chronic Pain Management Program.

08-03-12: UR performed by, MD. Reason for denial: Based on the medical records provided for review, 80 hours of CPM requested are not approved. Compensable injury is strain of low back, neck, left knee and right shoulder. Per ODG, these conditions resolve in 4-6 weeks. The claimant is a. This is a light PDL. She may return to work without restrictions is she wishes. However, per psych counseling notes she has plans for retirement. More importantly, there is no objective information discussing any improvement over the previously approved 6 sessions of psych counseling. None of the notes discussed her current medications regarding prescriber, how long she has been on medications and any monitoring of her progress or lack of progress while on these medications. This is not the standard for treating anxiety/depression per treatment guidelines.

08-06-12: Request for Reconsideration dictated by, DC. The claimant has exhausted all lower levels of care and is pending no additional procedures. ODG from the Work Loss Data Institute consider tertiary chronic interdisciplinary pain programs as the standard of treatment. The claimant meets the criteria for the

general use of multi-disciplinary pain management program, according to ODG guidelines, chronic pain chapter. Medical necessity for services to be rendered is clearly documented in this case.

09-28-12: UR performed by PhD. Reason for denial: This is a request for a reconsideration on 80 hours of CTMP. NOTE: The request also states that a request is pending for spine surgery, and for a spinal injection. Therefore, all treatment has not been exhausted, which is one of the criteria for participation in CPMP. The denial of CPMP was based on the fact that the patient has achieved her employment PDL, but has not returned to work, because she is planning on retiring. Also, there was no documentation of progress in psychotherapy, and no discussion of medications. Since the claimant still has a request for surgery pending from the same MD who sent the patient for CPMP, and there is no evidence that the referring MD is hoping to avoid a controversial surgery, then lower levels of care cannot be said to have been exhausted. Request is denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

In this case, all treatments have not been exhausted. The notes state that she received 6 psychotherapy treatments without success. Yet she has reached her employment PDL at a sedentary level. One of the criteria for participation in CPMP is that all treatment has been exhausted and to reach PDL for the ultimate goal to return to work. The denial of CPMP was based on the fact that the patient has achieved her employment PDL, but has not returned to work, because she is planning on retiring. Since the claimant still has options for surgery pending from the same MD who sent the patient for CPMP, and there is no evidence that the referring MD is hoping to avoid a controversial surgery, then lower levels of care cannot be said to have been exhausted. Therefore, after reviewing the medical records provided and documentation, the request for 97799, Chronic Pain Management, per hour 10 Sessions/80 Hours (5 days a week for 2 weeks) is not medically necessary and denied.

Per ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> pain rehabilitation programs may be considered medically necessary in the following circumstances: (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications</p>
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	<p>(particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.</p> <p>(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.</p> <p>(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following:</p> <p>(a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment;</p> <p>(b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected;</p> <p>(c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed;</p> <p>(d) An evaluation of social and vocational issues that require assessment.</p> <p>(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.</p> <p>(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.</p> <p>(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.</p> <p>(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.</p> <p>(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.</p> <p>(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.</p> <p>(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and</p>
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	<p>objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.</p> <p>(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.</p> <p>(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).</p> <p>(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.</p> <p>(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.</p> <p>(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.</p> <p><u>Inpatient</u> pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don’t have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; Functional restoration programs.</p>
<p>Chronic pain programs, early intervention</p>	<p><i>Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach:</i></p> <p>(a) The patient’s response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis.</p> <p>(c) Risk factors are identified with available screening tools or there is a previous medical history of delayed recovery.</p>

	<p>(d) The patient is not a candidate where surgery or other treatments would clearly be warranted.</p> <p>(e) Inadequate employer support or evidence of work organizational factors limiting return to work without interventions.</p> <p>(f) Evidence of psychosocial barriers that make return to work unlikely.</p> <p>(g) Loss of employment or evidence of partial disability involving ability to perform only “part-time” work or work with “light-duty” restrictions for greater than 4 months. (Mayer, 2003) (Gatchel, 2003) For general information see Chronic pain programs.</p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**